STATE OF IOWA

Family and Medical Leave Act (FMLA)
Employer Response

TO BE COMPLETED BY THE EMPLOYEE'S SUPERVISOR (please print or type)

Employee Name: _____ **SSN:** _____

Department: _____

On (date), _____, you notified the department of your need to take leave due to (check one):

☐ the birth, care after birth, adoption, or foster placement of a son or daughter; or

☐ a serious health condition that renders you unable to perform work at all or any one of the essential functions of your job; or

☐ a serious health condition affecting your spouse, child, or parent for which you are needed to provide care.

You have requested that your leave begin on (date) _____ and that you anticipate your need for the leave to end on or about (date) _____.

Your request for leave has been (check one): ☐ Approved ☐ Denied

Your leave (check one): ☐ ***will*** or ☐ ***will not*** be counted against your annual FMLA leave entitlement.

If denied, provide reason/s: _____

If your leave is designated as FMLA qualifying, the following provisions apply:

1. You (check one): ☐ ***will*** ☐ ***will not*** be required to furnish medical certification of a serious health condition within 15 calendar days of your request. If required, you must furnish certification by (insert date) _____. Failure to return the appropriate medical certification may result in disciplinary action (absent extenuating circumstances or as provided for in collective bargaining agreement). IMPORTANT: FMLA leave for the birth, adoption or foster placement of a son or daughter is the only serious medical condition that does not require medical certification. However, completion of a "State of Iowa Family and Medical Leave Act (FMLA) Application" (CFN 552-0599) form is required.

2. We will require that you substitute accrued paid leave for FMLA leave. The following conditions will apply:

   _____

3. The State of Iowa is required to maintain your health and dental insurances during periods of FMLA leave by paying the State's share of your insurance premiums. If provisions of your insurance plans require you to pay a portion of the monthly premiums, you will continue to be responsible for your share of the premiums.

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4. You will have a 30 day grace period in which to make premium payments. If payments are not made timely, your group health, dental, and supplemental life insurances will be canceled retroactively to the first day of the month in which the premium was not paid. You will be notified in writing at least 15 calendar days prior to any retroactive cancellation of any insurance coverage. If you elect to discontinue your health, dental, and supplemental life insurances (if applicable), you will be restored to no more than the same level of benefits as when your leave began. Upon completion of the necessary insurance applications (underwriting not required), your insurance coverages will become effective the first of the month following your return to work.

5. The State of Iowa will maintain your basic life and long term disability insurance premiums during periods of FMLA leave.

6. If the FMLA leave is for your own serious health condition, you will be required to provide your employer with a written "fitness for duty" certification before you return to work. If such certification is not received, your return to work may be delayed until certification is provided.

7. If the circumstances of your FMLA leave change and you are able to return to work earlier than identified originally, you will be required to notify your employer at least two work days prior to the date of your return.

8. If your FMLA leave is approved and additional FMLA leave is necessary (consecutive or intermittent) due to reasons not stated on your original application and certification of health care provider forms, you will be required to recertify.

9. You will be reinstated to your same position or an equivalent position with the same pay, benefits and working conditions (shift and schedule) and the same or substantially similar duties, conditions, privileges, and status which require equivalent skill, effort, responsibility, and authority.

If you have any questions regarding FMLA leave, please contact me.

_____ _____

(Supervisor's Signature) (Date Signed)

CFN 552-0627 R 9/03